**DRUG - INDIVIDUAL FUNDING REQUEST (IFR) form**

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| Requesters are advised to review the **Mid and South Essex, Integrated Care System (M&SE ICB),** IFR Policy and the guidance for Clinicians at: <https://www.midandsouthessex.ics.nhs.uk>  **This form is to be used for drug requests where the requesting clinician is of the opinion this individual patient has an exceptional healthcare need and is presenting a case for clinical exceptionality.**  Mid and South Essex ICB requires provider trusts and clinicians to take clinical commissioning policies into account in the advice and guidance given to patients prior to making the decision to treat a patient.  It is the responsibility of the referring clinician to ensure all the appropriate and required clinical information is provided to Mid and South Essex ICB. This includes full text copies of all the published papers of clinical evidence that have been cited, a list of the published papers submitted and an indication of which points within them are relevant in respect to the IFR application and criteria. Requests will only be considered on the information provided in the application and supporting papers.  The information requested at question 2f and 2i is collected for monitoring purposes in an anonymised format to assist Mid and South Essex ICB in ensuring that we are complying with the Equality Act 2010. This information will be redacted prior to sharing with decision makers.  **Applications presenting incomplete information will be returned for amendment / completion prior to consideration by Mid and South Essex ICB.** | | | | |
| **Before completing and submitting this form you MUST first consider the following:**   * **Has this request been approved by the Drug & Therapeutic Committee (D&TC) or equivalent?** * **Is this a request for a treatment that is currently commissioned by NHS England?**   (e.g. Cancer drug) – If unsure please see <https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/> or email [england.ift@nhs.net](mailto:england.ift@nhs.net) for advice.   * **Are there like to be any other patients with similar clinical circumstances across Mid & South Essex who could also benefit from the treatment you are requesting?**   If YES, a clear arguable case for exceptionality needs to be presented to demonstrate how this patient is clinical difficult to the cohort.   * **Is it likely that the claims of exceptionality could also apply to other patients within the cohort?**   If YES, alternative routes will need to be discussed for this intervention. | | | | |
| **Section 1 - PROVIDER DETAILS** | | | | |
| **1a) Name of Provider** | Click here to enter text. | | | |
| **1b) Name of clinician who will undertake the intervention** | Click here to enter text. | | | |
| **1c) Job title/role** | Click here to enter text. | | | |
| **1d) Secure NHS email** | Click here to enter text. | | | |
| **1e) Telephone number** | Click here to enter text. | | | |
| **1f) Application reviewed by Chief Pharmacist or nominated deputy (in the case of a drug intervention)** | **Name:** | | Click here to enter text. | |
| **Signature or email confirmation:** | | Click here to enter text. | |
| **Section 2 – PATIENT / GP DETAILS** | | | | |
| **2a) Patient first name** | Click here to enter text. | | | |
| **2b) Patient last name** | Click here to enter text. | | | |
| **2c) Patient NHS Number** | Click here to enter text. | | | |
| **2d) Patient hospital number** | Click here to enter text. | | | |
| **2e) Patient date of birth** | Click here to enter a date. | | | |
| **2f) Patient age at time of submission** | Click here to enter text. | | | |
| **2g) Gender** | Click here to enter text. | | | |
| **2h) Ethnicity** | Choose an item. | | | |
| **2i) Disability** | **Yes**   **No**  Click here to enter text. | | | |
| **2j) Patient’s address** | Click here to enter text. | | | |
| **2k) Patient’s postcode** | Click here to enter text. | | | |
| **2l) GP Name** | Click here to enter text. | | | |
| **2m) GP Practice name** | Click here to enter text. | | | |
| **2n) GP postcode** | Click here to enter text. | | | |
| **Section 3 – Intervention Requested** (NB: Intervention refers to requested treatment, investigation, etc) | | | | |
| **3a) Patient Diagnosis**  (for which intervention is requested) | Click here to enter text. | | | |
| **3b) Clinical history**  Please provide a brief clinical history of the patient outlining:   * Current problem * Any co-morbidities * Investigation results for current problem * Treatment given so far * Abilities in independence and self-care   Attach most recent correspondence between GP and referring consultants if appropriate.  (Please extend space if necessary) | **What is the patient’s clinical status at this point? What is the severity of the current and any co-existing problem? Where possible use standard scoring systems e.g. WHO status, DAS scores, 6 minute walk test, cardiac index etc.** | | | |
| Click here to enter text. | | | |
| **3b) Details of intervention** (for which funding is requested).  If the intervention forms part of a regimen, please document the full regimen. | | | | |
| **Name of intervention:** | Click here to enter text. | | | |
| **Dose and frequency:** | Click here to enter text. | | | |
| **Planned duration of intervention:** | Click here to enter text. | | | |
| **Route of administration:** | Click here to enter text. | | | |
| **Anticipation cost**  **(inc VAT)** | N.B. This must be completed  Click here to enter text. | | | |
| **Is requested intervention part of a clinical trial?** | **Yes**   **No**  If **Yes,** give details (e.g. name of trial, is it an MRC/National trial?)  Click here to enter text. | | | |
| Is the drug funded through a clinical trial ?  **Yes**  **No** | | | |
| **What would be the standard intervention at this state?** | Click here to enter text. | | | |
| **What would be the expected outcome from the standard intervention?** | Click here to enter text. | | | |
| **What are the Exceptional Circumstances that makes the standard intervention inappropriate for this patient?** | Click here to enter text. | | | |
| **How does this patient differ from the general population of patients with this condition?** | Click here to enter text. | | | |
| **Why is this patient more likely to respond to the requested therapy than the general population with the same condition?** | Click here to enter text. | | | |
| **Summary of previous intervention(s) this patient has received for the condition.**  **Reasons for stopping may include:**   * **Course completed** * **No or poor response** * **Disease progression**   **Adverse effects/poorly tolerated** | **Dates** | **Intervention (e.g., drug / surgery)** | | **Reason for stopping\* / Response achieved** |
| Click or tap to enter a date. | Click here to enter text. | | Click here to enter text. |
| Click or tap to enter a date. | Click here to enter text. | | Click here to enter text. |
| Click or tap to enter a date. | Click here to enter text. | | Click here to enter text. |
| Click or tap to enter a date. | Click here to enter text. | | Click here to enter text. |
| **Anticipated start date** | Click here to enter a date. | | | |
| **CLINICAL EVIDENCE** | | | | |
| **Is requested intervention licensed for use in the requested indication in the UK?** | **Yes**   **No**  (refer to pharmacy if required) | | | |
| **Has the Trust Drugs and Therapeutics Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device). For Cancer has the local Cancer Network Board approved the requested intervention for use.** | Drugs and Therapeutics Committee  **Yes**   **No**  Local Cancer Network Board  **Yes**   **No**  If **No,** Committee Chair or Chief Pharmacist approved:  **Yes**   **No** | | | |
| **Additional Information to Support your Request. Failure to provide adequate details may result in a delay regarding a final funding decision** | **\*PUBLISHED[[1]](#footnote-1) trials/data - please furnish electronic copies of journal articles/ scanned/ faxed/weblinks**  Click here to enter text. | | | |
| **How will you monitor the effectiveness of this intervention?** | Click here to enter text. | | | |
| **Detail the current status of the patient according to these measures.** | Click here to enter text. | | | |
| **What would you consider to be a successful clinical outcome for this intervention in this patient? Please state added benefits of this treatment, e.g., QOL, life expectancy, impact on or facilitating subsequent treatment, etc.** | Click here to enter text. | | | |
| **What is the anticipated toxicity of the intervention for this patient?** | Click here to enter text. | | | |
| **What are your criteria for stopping treatment? Define fully using objective** | Click here to enter text. | | | |
| **What are your criteria for stopping treatment? Define fully using objective measurements or recognised assessment scales.** | Click here to enter text. | | | |
| **Are there any patient factors (clinical) that need to be considered?** | **Yes**   **No**  If **Yes**, please give details:  Click here to enter text. | | | |
| **Form completed by** | **Name:** Click here to enter text. | | | |
| **Signature or email confirmation:**  Click here to enter text. | | | |
| **SECTION 4 – SUBMIT** | | | | |
| When you are satisfied that you have completed all relevant sections, you will need to submit the request for consideration by Mid & South Essex ICB, IFR Team. Please note requests will be managed within a maximum period of 40 working days from the date of the receipt of an application to the date of the letter from either the Funding team or Panel.  If the IFR Team needs more information they will contact you to ask that you provide more details and if this happens, the timeline for the request will be ‘paused’ until this is received | | | | |
| **Clinicians are required to disclose all material facts to Mid & South Essex ICB as part of this process.**  **Are there any other comments/considerations that are appropriate to bring to the attention of the IFR Team?** | Click here to enter text. | | | |
| **Please complete in full and return this form to:** [**mseicb.ifrfunding@nhs.net**](mailto:mseicb.ifrfunding@nhs.net)  **(*hand written forms will not be accepted*)** | | | | |
| **ICB USE ONLY** | | | | |
| **Received by:** | Click here to enter text. | | | |
| **Considered by:** | Click here to enter text. | | | |
| **Chief Pharmacist or nominee:** | Click here to enter text. | | | |
| **Date:** | Click or tap to enter a date. | | | |
| **Recommendation from Exceptional Clinical Circumstances Panel (or other route):**  **Yes**   **No** | | | | |

1. *Full published papers, rather than abstracts, should be submitted, unless the application relates to the use of an intervention in a rare disease where published data is not available* [↑](#footnote-ref-1)